

January 26, 2016

The Honorable Johnny Isakson
Co-Chair

The Honorable Mark Warner
Co-Chair

Bipartisan Chronic Care Working Group
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Isakson and Chairman Warner:

Thank you for the opportunity to comment on the Policy Options Document of the Bipartisan Chronic Care Working Group. We believe that this work will go a long way toward addressing the complex care needs experienced by many Medicare beneficiaries. The Roger C. Lipitz Center for Integrated Care at Johns Hopkins Bloomberg School of Public Health conducts extensive research on the profile, access, affordability, quality of care, costs and utilization of individuals with complex care needs, and their family caregiver. We offer three overarching comments on the Policy Options Document, followed by specific responses to the policies under consideration.

First, we believe that the chronic care definition needs to consider and include those with complex care needs, that being either a functional physical limitation (e.g. difficulty with Activities of Daily Living (ADLs)) and/or cognitive limitations, in a more consistent way. While chronic conditions and complex care needs are related, they are separate concepts in that not all beneficiaries with complex care needs have multiple chronic conditions, and their care needs and models of care delivery may differ. For example, those with limited mobility may be particularly in need of services in the home, and those with cognitive limitations may be particularly at risk of delirium or other complications if hospitalized.

Throughout the document, functional and cognitive limitations were mentioned sporadically. It would be best to systematically and explicitly recognize this population and their needs, so that we are cognizant of how the proposed policies may affect them. In most cases, they are likely to benefit greatly from the changes described in the document, particularly those that recognize the mobility challenges faced by those with functional or cognitive impairments, either because it is physically challenging or mentally distressing for them to leave the home. Additionally, this is a high-cost population- the health care spending for individuals

with chronic conditions almost doubles when they also have a functional limitation¹. This broader definition should be used for risk-adjustment, eligibility for certain types of services, and quality measurement. To do this effectively, Medicare needs to collect information on both functional and cognitive impairment in their surveys and enrollment files.

Second, and in line with the bipartisan goals described in the Policy Options Document, to facilitate the delivery of high quality care, improve care transitions, and produce stronger patient outcomes, any changes should consider and support the role of the family caregiver. Approximately 40 percent of Medicare beneficiaries report being accompanied to routine medical visits by a companion², nearly always by the same person³. Embracing and supporting the family caregiver should be a fundamental part of the changes proposed in the Policy Options Document. For example, integration of the family caregiver, access to information and their education on how to care for the beneficiary should be built into the tasks completed by the physician as part of the care management process.

Third, the document references the intention that “any future legislation must realize savings or it must be budget neutral”. It is important to remember that budget neutrality can be achieved in two ways. The first is for any additional costs to be offset by savings; the second is to include revenues from beneficiaries through premiums, co-payments as well as other financing sources. Many individuals and their families value the services that would enable those with complex care needs to continue to live independently and may be able and willing to contribute toward their cost. Restricting policies to only the first category will miss opportunities to improve the quality of life and well-being of Medicare beneficiaries most at risk of inadequate care.

We would also like to offer more specific comments on the policies proposed.

- We strongly support the expansion of the Independence at Home Model of Care. In addition to HCC risk scores as a basis for eligibility, the degree of physical and or cognitive functional impairment should be incorporated as a basis for eligibility, risk adjustment, and quality measurement.
- In addition to the Independence at Home Model of Care, the Working Group should consider having a parallel recommendation for Hospital at Home. As the name suggests, this intervention provides hospital care in the home for four conditions: community-acquired pneumonia, exacerbation of chronic obstructive pulmonary disease, exacerbation of chronic heart failure, and cellulitis. This model has been tested in three Medicare managed care health

¹ Anderson, G. (2010). *Chronic Care : Making the Case for Ongoing Care*. Robert Wood Johnson Foundation. Princeton.

² Wolff, J. L., & Roter, D. L. (2008). Hidden in plain sight. *Archives of Internal Medicine*, 168(13), 1409–1415.

³ Wolff, J. L., Boyd, C. M., Gitlin, L. N., Bruce, M. L., & Roter, D. L. (2012). Going It Together: Persistence of Older Adults' Accompaniment to Physician Visits by a Family Companion. *Journal of the American Geriatrics Society*, 60(1), 106–112.

systems at two sites and a Veterans Administration medical center. Costs were \$2,398 lower in those who received Hospital at Home, compared to those in an acute care setting^{4,5}.

- In many sections, the Policy Options Document references changes to the care management fee. We agree that the care management fee needs to be rethought such that the emphasis is placed on constructing a population-based payment, much like the comprehensive primary care/patient-centered medical home payment models, rather than a time-based payment. The care management fee should be converted to a per Medicare beneficiary per month (PMPM) payment for a qualified provider organization where the beneficiary would designate a provider organization as the primary source of care, be it a physician practice, clinic, health system, ACO, or other provider organization. If both the beneficiary meets the eligibility criteria as has been laid out on page 11, and the provider meets certain requirements (typical of NCQA's patient-centered medical home), then that provider would be eligible for the PMPM payment. The level of the payment could vary with the risk characteristics of the beneficiary, including functional impairment. We agree with what is proposed to "encourage beneficiary use of chronic care management services" on page 23 that there should be no beneficiary co-payment for these services.
- In addition to what is being proposed to "provide flexibility for beneficiaries to be part of an ACO", this policy should include reduced beneficiary cost-sharing for within ACO network utilization.
- We strongly support and encourage the inclusion of family caregivers in the development of quality measures and believe that it should not be restricted to those who are caring for individuals with Alzheimer's and dementia.
- The policy recommendation to integrate behavioral health and chronic disease is excellent. In addition we suggest a parallel policy option that would address the need for in-home care management services for beneficiaries with Alzheimer's disease and other forms of dementia. Innovative models of care, like the Maximizing Independent (MIND) at Home intervention, support individuals with cognitive impairment and their care companion, to continue living in the home and manage their health needs, as well as achieve savings through delayed or avoided long-term institutional care. ⁶

⁴ Leff, B. (2005). Hospital at Home: Feasibility and Outcomes of a Program To Provide Hospital-Level Care at Home for Acutely Ill Older Patients. *Annals of Internal Medicine*, 143(11), 798.

⁵ Davis, K., Buttorff, C., Leff, B., Samus, Q. M., Szanton, S., Wolff, J. L., & Bandelei, F. (2015). Innovative Care Models for High-Cost Medicare Reform to Accelerate Adoption. *American Journal of Managed Care*, 21(5), e349–e356.

⁶ Samus, Q. M., Johnston, D., Black, B. S., Hess, E., Lyman, C., Vavilikolanu, A., ... Lyketsos, C. G. (2014). A multidimensional home-based care coordination intervention for elders with memory disorders: The maximizing independence at home (MIND) pilot randomized trial. *American Journal of Geriatric Psychiatry*, 22(4), 398–414.

Thank you for the opportunity to comment on the work of the Bipartisan Chronic Care Working Group and to be part of this important effort of improving the Medicare program to better serve the beneficiaries.

Sincerely,

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